COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
OFFICE OF THE MEDICAL DIRECTOR

02.1 PARAMETERS FOR ASSESSMENT AND MANAGEMENT OF CLIENTS AT RISK FOR SUICIDE

Revised November 2002
(For revision, see IV., B., 2.)

I. INITIAL CONTACT

A. Screening

Upon first telephone or face-to-face contact, intake workers should make efforts to determine the urgency for clinical contact based upon the client's:

1. Level of emotional distress,
2. Recent behavior,
3. Content of statements e.g., suicidal, homicidal thoughts, and/or
4. Nature of situation described.

B. Transfer to a Clinician

1. Expression or description of suicidal thought, plans, statements or actions by a client or other informant to a clinical agency, or description of during an initial (or subsequent) contact should be **immediately** documented and referred to a designated clinician, **e.g., Officer of the Day.**

2. The person initially handling the contact in which suicidal information is disclosed should make every effort to get the exact name of the client or informant, telephone number, address, and current location before transferring the client to a clinician.

C. Information Provided by an Informant

Statements by an informant about a client's suicidal ideation, statements or behavior should always be considered seriously and thoroughly assessed even though they may contradict the client's statements or be denied by the client.

D. Initial Clinical Contact

1. Screening for suicidal intent should be part of every initial clinical telephone or face-to-face contact.

2. The designated clinician should perform and document an emergency assessment in order to ascertain the presence of significant suicide risk and need for emergency management.

II. EMERGENCY SUICIDE RISK ASSESSMENT

A. Components

The Emergency Suicide Risk Assessment should include the:

1. Exact reason the client has contacted the agency or otherwise came to the agency's attention,
2. Presence of any acute stressors
3. Specific nature of help the client desires (or refusal of help.)
4. Degree to which the client experiences hopelessness,

5. Type of suicidal thoughts, statements or plans,
6. Practicality and lethality of plans
7. Nature of previous attempts,
8. Potential for harm to others
9. Presence or absence of external incentives for suicidal statements,
10. Acute risk factors, i.e. new onset insomnia, anxiety,
11. Evidence of substance-related pathology
12. Evidence of other mental disorders, and
13. Availability of responsible and concerned significant others**.**

B. Determination of Level of Risk

The emergency risk assessment should clearly document:

1. The estimated degree of suicide risk present, stated as Low, Moderate or High risk, and

2. The basis for determination, e.g. history, behavioral observations, statements of the client or significant others.

C. Emergency Risk Assessment Follow-Up

After an emergency risk assessment, the clinician may:

1. Cause the client to be taken into 5150 or 5585.55 custody,
2. Initiate a full clinical assessment,
3. Schedule the client for additional assessment and a follow up appointment, or
4. Refer the client to appropriate community resources.

D. Involvement of Others/ Safety Issues / Confidentiality

1. Significant others should be notified and engaged to provide support and remove means for suicide as clinically indicated and permitted by statutes, policies and procedures regarding confidentiality.

2. When consent is not possible and a client is at imminent risk of suicide, the clinician should limit the disclosure of confidential information to only that which is necessary to obtain emergency intervention in order to save life.

3. Other agencies, e.g., law enforcement, public health, should be notified depending on the nature and acuteness of risks to others.

III. COMPREHENSIVE SUICIDE RISK ASSESSMENT

A. Indications

1. A Comprehensive Suicide Risk Assessment should be completed for clients:

    a. Who have recently made a suicide attempt,
    b. Complain of suicidal thoughts,
    c. Admit to suicidal thoughts when questioned, and/or
    d. Who demonstrate suicidal behavior.

2. In addition to clients who express suicidal ideas or intent,

clients presenting with history of prescribed or illicit drug overdose, single-car auto accidents, "risk taking behavior", and "accidental" self-inflicted trauma should be routinely evaluated for suicidal thoughts.

3. Comprehensive clinical assessment for clients believed at risk for suicidal behavior should be expeditiously initiated, and should be ongoing for as long as clinically indicated.

B. Documentation

The comprehensive assessment should be completely documented in the medical record, and suicide-related components of the assessment should be easily found and prominently noted when significant risk is present.

C. Components

1. Assessment should at minimum include the complete evaluation for mental disorders and acute stressors performed at the agency in which the client has sought and been offered services.

2. The assessment should specifically include known factors that affect suicide risk, including the:

    a. Reason the client has contacted the agency,
    b. Presence of any acute stressors,
    c. Specific nature of help the client desires (or refusal of help,)
    d. Degree to which the client experiences hopelessness,
    e. Type of suicidal thoughts or plans,
    f. Practicality and lethality of plans,
    g. Nature of previous attempts,
    h. Potential for harm to others,
    i. Presence of absence of external incentives for suicidal statements,
    j. Presence of mental disorders,
    k. Relevant demographic information,
    l. Strength of the client's support system, and
    m. Other factors that indicate an increased risk such as intoxication, preparations made for death, i.e. the giving away of prized possessions, agitation, feeling a pressure to decisively act.

D. Assessment of Lethality

Assessment should include to the extent possible factors in the client's physical and psychosocial environment that may increase suicidal risk, e.g., presence of weapons or potentially lethal medications, loss of significant others especially due to suicide.

E. Assessment Summary

The assessment should clearly document the estimated degree of suicide risk present, stated as Low, Moderate or High risk and the basis for determination, e.g. history, behavioral observations,

statements.

F. Treatment Plan Documentation

The treatment plan derived from the assessment should document the manner in which the estimation was derived, the manner in which the degree of suicide risk has influenced the treatment plan, and any specific measures taken to decrease the risk of suicide.

G. Measurement of Risk

Specific instruments to measure suicide risk should be interpreted by qualified clinicians, and should not be used in absence of additional competent clinical assessment. When the assessment of suicide risk differs from a previous assessment of suicide risk, the change should be explicitly noted, the reasons determined, and the manner in which the change affects treatment (or why treatment remains unchanged) should be documented.

H. Involvement of Others/Confidentiality

1. Within the limits of confidentiality, significant others should be notified of assessed suicide risk and their help enlisted when clinically indicated.

2. Other agencies, e.g., law enforcement, healthcare systems, should be notified depending on the nature and acuteness of suicide risk and risks to others.

IV. MANAGEMENT OF CLIENTS AT RISK FOR SUICIDE

A. Reassessment

1. Clients at risk for suicide should be regularly reassessed to determine changes in the degree of risk, and treatment plans should be adjusted accordingly.

2. The client's environment should be continually reassessed to the extent practical to detect and mitigate risk factors, e.g., guns, lethal medications.

B. Safety Contract Considerations

1. A "Safety Contract" should not be considered in and of itself as a strategy to lower the risk for suicide.

2. An individual's willingness to "contract" not to commit suicide (safety contract) should not be considered in and of itself to lower the risk of suicide. **(Revised 11-5-02)**

C. Involuntary Hospitalization

Involuntary hospitalization should be considered and, where appropriate, immediately implemented for clients at significant risk for suicide.

D. Engagement of Support System

Within the limits of confidentiality, the client's support system should be kept apprised of the client's suicide risk, and their help should be enlisted whenever clinically appropriate.

E. Therapeutic Interventions

Provision of hope and motivation to live should be an essential psychotherapeutic intervention for clients at risk for suicide.

F. Medication Considerations

Prescription of psychiatric medication should be undertaken with caution in clients at risk for suicide because of the risk of intentional overdose. The risks versus benefits assessment involved with such a decision should be explicitly documented, along with any steps taken to mitigate risk factors, e.g., having others keep medication for the client.

G. Emergency Support System

Clients at risk for suicide should be provided with a 24/7 method of establishing contact with mental health resources that can effectively intervene when necessary to decrease suicide risk.

VI. POSTVENTION

In addition to offering supportive services to the families/significant others of a victim of suicide, referrals to the unique services tailored to the survivors of suicide should be considered, e.g. the "Survivors After Suicide" group.